EXHIBIT 2

FEE SCHEDULE
AND
ATTACHMENTS

FEE SCHEDULE

MENTAL HEALTH SERVICES ACT
ENHANCED EMERGENCY SHELTER PROGRAM FOR TRANSITION AGE YOUTH

1. REFERRALS

Clients shall be referred to Contractor solely by the Department of Mental Health (DMH) as follows:

- **a.** A DMH Navigator or DMH Case Manager shall be the gatekeeper responsible for identifying the housing needs of the Client, verifying that he/she meets the target TAY population as described in Exhibit 1-Statement of Work (SOW);
- **b.** A DMH Navigator or DMH Case Manager shall authorize admission to Contractor's Enhanced Emergency Shelter Program (EESP) site, informally screening the Client to determine the level of services needed, and if needed, arranging for a referral to either a Full Service Partnership (FSP) agency or other appropriate community-based mental health agency; and
- **c.** The Contractor's Case Manager will be responsible for keeping in regular contact with the Client, working towards establishing benefits, stabilizing the Client, preparing each Client's treatment plan, assisting in the placement of each Client in more permanent living arrangement, and keeping the referring DMH Navigator or DMH Case Manager abreast of the progress that is being made.

2. TERM OF STAY

The maximum length of stay in any ESSP site shall not exceed more than 60 continuous nights per client, per episode. Subsequent extensions may be made upon review and written approval by DMH ONLY.

3. PAYMENT RATE

DMH shall pay to Contractor the following nightly rate of:

a. Up to $121.00 per Client, per overnight stay; and
b. For Clients with children, $60.50 shall be paid per child per night, with a maximum payment for two (2) children per night;

Any belongings left behind at the EESP site by Client after his/her stay shall be stored by Contractor for up to 15 days without incurring any fees against the Client or DMH.

4. INVOICES

Invoices shall be submitted monthly, in arrears, and within 60 days of the last day of service. If invoice is not submitted within 60 days from the last day of service, payment may be delayed at the discretion of the County.

Contractor shall use the attached billing statement (see Exhibit 2-Attachment I) when submitting invoices. The invoice shall include: the name of Client; Integrated Behavioral Health Information System (IBHIS) number and/or social security number, if available; date of birth (DOB); first day of authorized stay; and last day of authorized stay. Legible copies of daily sign-in log sheets (see Exhibit 2-Attachment II) with Client and shelter staff signatures must accompany the invoices as verification of the Client's stay in the shelter. DMH staff will review the invoices to ensure that the authorized services and supports rendered are compliant with the requirements described in Exhibit 1, SOW. Any additional services must be approved by DMH before they are rendered to be eligible for reimbursement.

All Invoices under this Master Agreement shall be submitted in two (2) copies to the following address:

Joo Yoon, LCSW
County Program Manager
County of Los Angeles – Department of Mental Health
550 S. Vermont Avenue, 4th Floor
Los Angeles, CA 90020

5. PAYMENT PROCEDURES

Payment to Contractor shall be based on timely, complete and original invoices. Upon receipt of timely, complete and original invoices DMH shall review and confirm services rendered per the terms of this Contract. DMH shall make payment to Contractor within forty-five (45) days of the date the invoice was approved for payment. If any portion of the invoice is disputed by DMH, DMH shall pay Contractor for undisputed services charges and work diligently with Contractor to resolve the disputed portion of the claim in a timely manner.

DMH shall make payments payable to Contractor. DMH shall send payments to:

Name of Agency
Address of Agency
City, State Zip Code

6. DESIGNATED DMH CONTACT PERSON

All questions and correspondence shall be directed to:

Joo Yoon, LCSW
County of Los Angeles – Department of Mental Health
550 South Vermont Avenue, 4th Floor
Los Angeles, CA 90020
(213) 351-6669

7. LIIMITATIONS OF PAYMENT BASED ON FUNDING RESTRICTIONS

This Contract shall be subject to any restrictions, limitations, or conditions imposed by the State which may in any way affect the provisions or funding of this Contract, including but not limited to, those contained in the State's Budget Act.

This Contract shall also be subject to any additional restrictions, limitations, or conditions imposed by the federal government which may in any way affect the provisions or funding of this Contract.

In the event that the County's Board of Supervisors adopts, in any fiscal year, a County Budget which provides for reductions in County Contracts, the County reserves the right to reduce payment obligation under this Contract correspondingly for that fiscal year and any subsequent fiscal years during the term of this Contract (including any extensions) and the services to be provided by the Contractor under this Contract shall also be reduced accordingly.

County of Los Angeles - Department of Mental Health

MHSA ENHANCED EMERGENCY SHELTER PROGRAM FOR TRANSITION AGE YOUTH (TAY)

INVOICE

Invoice Date:

Invoice Number

Contractor Name: ***Shelter Location:*** ***Mo/Yr. of Service:***

Contract Number:

Daily rate for age > 18

Daily rate for age < 18

	Name of Client Last, First	Integrated System #	Date of Birth	First Day Authorized	Discharge Day	Age at Admission Date	Nights	Rate	Net Claim
1						0	-	-	-
2						0	-	-	-
3						0	-	-	-
4						0	-	-	-
5						0	-	-	-
6						0	-	-	-
7						0	-	-	-
8						0	-	-	-
9						0	-	-	-
10						0	-	-	-
11						0	-	-	-
12						0	-	-	-
13						0	-	-	-
14						0	-	-	-
15						0	-	-	-
16						0	-	-	-
17						0	-	-	-
18						0	-	-	-
19						0	-	-	-
20						0	-	-	-
21						0	-	-	-
22						0	-	-	-
23						0	-	-	-
24						0	-	-	-
25						0	-	-	-
26						0	-	-	-
27						0	-	-	-
28						0	-	-	-
29						0	-	-	-
30						0	-	-	-
	TOTAL						-		-

I hereby certify that all information contained above are services and costs eligible under the terms and conditions for reimbursement under the MHSA TAY Enhanced Emergency Shelter Program Services and is true and correct to the best of my knowledge. All supporting documentation will be maintained in a separate file for the period specified under the provisions of the Mental Health Services Agreement Community Services and Supports Plan.

I hereby certify all the clients listed above:

(Shelter Director/Manager signature) Date

(Print Name of Shelter Director/Manager)

ma110810

Approved (DMH TAY Program Manager) Date

Approved (DMH-TAY Analyst) Date

Approved (DMH- M.H. Clinical Program Manager III) Date

Enhanced Emergency Shelter Program Participant Daily Sign-In Sheet

(A new form must be used each month)

Client's Name: _____ **(a.k.a should be included)**

Month of Stay (circle): Jan Feb Mar Apr May Jun Jul Aug Sept Oct Nov Dec

All clients must sign-in and date each night spent at EESP.

Provider Name: _____

Shelter Address: _____

Signature	Date	Signature	Date	Signature	Date

I _____ **slept at the above address each night, and I signed this form daily.**

Name of EESP Client

_____

Signature of EESP Client **Date**

For Shelter Staff Use Only

EESP Provider Bed Night Certification

_____ **Total # of Bed Nights**

Y / N Total Nights: Total matches Signature and Invoice Data

_____ **Total # of Client Signatures**

Y / N All signatures are in permanent ink (no pencils)

By signing below I certify that I understand that reimbursement will only be provided for bed nights that have been approved by the Department of Mental Health AND for which the Client has signed AND dated the sign-in sheet. Staff must verify signatures on a daily basis, and all information must be legible. The designated staff is required to sign this form at the end of the 29 days, the end of the month of stay or upon client's discharge whichever comes first. The designated staff is assigned by the EESP provider.

_____

Staff Signature **Date**

County of Los Angeles Department of Mental Health

MHSA ENHANCED EMERGENCY SHELTER PROGRAM FOR TRANISITION AGE YOUTH (TAY)

ENHANCED SERVICES CERTIFICATION FORM

Agency Name & Number: **Shelter Location: (If Different from Headquarters Address)** **Mo/Yr. of Service:_____**

ENHANCED SERVICES	Client Name:	
(1) Life Skills Counseling, 1.5 Hours Per Day		
☐ Benefit Establishments	Initials:	Date:
☐ Budgeting/Money Management	Initials:	Date:
☐ Obtaining California Identification	Initials:	Date:
Education Assistance (Provide info for GED, Diploma, enrolling in educational programs, etc.)	Initials:	Date:
Employment Assistance (Resume Writing, Job Search, Interviewing Skills, etc.)	Initials:	Date:
☐ Personal Counseling (Interpersonal Skills & Communication Skills, etc.)	Initials:	Date:
☐ Personal Counseling (Anger & Stress Management, etc.)	Initials:	Date:
☐ Other _____	Initials:	Date:
(2) Healthy Living Group, 3 Hours Per Week		
Health & Hygiene Education (Personal Care and Grooming)	Initials:	Date:
☐ Safe Sex Education (HIV/AIDS, STDS, etc.)	Initials:	Date:
☐ Nutrition Education/Healthy Eating	Initials:	Date:
☐ Dangers of Drug & Alcohol Use (Illegal and Legal Info & Referral)	Initials:	Date:
☐ Other	Initials:	Date:
(3) Transportation		
☐ Bus Fare	Initials:	Date:
☐ Taxi Voucher	Initials:	Date:
☐ Van Services	Initials:	Date:

I hereby certify that all information contained above are services and supports eligible under the terms and conditions for reimbursement under the agreement of ENHANCED EMERGENCY SHELTER PROGRAM SERVICES FOR TRANISITION AGE YOUTH and is true and correct to the best of my knowledge. All supporting documentation will be maintained in a separate file for the period specified under the provisions of the Mental Health Services Agreement – Community Services and Supports and its Statement of Work and Fee Schedule.

I hereby certify all services listed above were provided to this client.

(Print Client's Name)	**Client's Signature**
(Print Name of Shelter Case Worker)	**Shelter Case Worker Signature**
(Print Name of Shelter Director/Manager)	**(Shelter Director/Manager Signature)**

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
TRANSITION AGE YOUTH DIVISION
Enhanced Emergency Shelter Program (EESP)
Group Attendance Sign-In Sheet
This form is to be included with each invoice.

Provider Name:
DMH Contract Number:
Month/Year of Service:

Date	Time	Name of Group	Print Client Name	Initials